**B.H.C. CONSENT FORM for COVID-19 Vaccination**

* **Why have the vaccination? Reduced chance of Covid 19 illness. It is free.**
* **It is your choice whether you have it or not. You will need two doses 12 weeks apart.**
* **Most side effects are mild. Medical experts advise that it is safe. There may be rare or unknown side effects.**
* **Some people may still get Covid 19 after vaccination. You must still follow precautions afterwards including masks, safe distancing, hand washing etc.**
* **Vaccination providers record all vaccinations. You can view your
vaccination record online through your Medicare, MyGov or MyHealthRecord accounts**

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| **Patient Information Dose**  **1 or 2** (office use)  |
| Name: Date of birth:  |
| Address: |
| Phone number: Medicare Card Number: Ref. No.   |
| Email: Gender: Male / Female / Other |
| Next of kin (emergency) Name: Phone: |
| Are you Aboriginal and / or Torres Strait Islander? YES NO  |
| Have you read and understood the information leaflet provided by the practice? YES NOPlease answer the following: Please ask doctor prior to vaccination if you have any concerns.

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| Yes | No |  |
|  |  | **Do you have any serious allergies, particularly anaphylaxis, to anything?****(rash, tongue swelling, breathing difficulties, breathing faster, wheeze)** |
|  |  | **Have you had an allergy reaction after being vaccinated before?**  |
|  |  | **Do you have a bleeding disorder?** |
|  |  | **Do you take any medicine to thin your blood (an anticoagulant therapy)?** |
|  |  | **Do you have a weakened immune system (immunocompromised)?** |
|  |  | **Are you pregnant or do you think you might be pregnant?** |
|  |  | **Are you breastfeeding?** |
|  |  | **Have you been sick with a cough, sore throat, fever or are feeling sick in another way?** |
|  |  | **Have you had Covid 19 before** |
|  |  | **Have you had a COVID-19 vaccination before?** |
|  |  | **Have you received any other vaccination in the last 14 days?**  |
|  |  | **Have you or do you use an Epipen?** |

**Consent to receive COVID-19 vaccine*** I confirm I have received and understood information provided to me on COVID-19 vaccination
* I confirm that none of the conditions above apply, or I have discussed these and/or any other special circumstances with my regular health care provider and / or vaccination service provider.
* I agree to receive a course of COVID-19 (two doses of the same vaccine)

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Guardian’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date / /**  |